

Dental Plan No Change Change Dental Plan Drop Dental Plan

To CHANGE your dental plan, select from the options below:

- Assurant Freedom Preferred Delta Dental PPO Plus Premier
 Assurant Heritage Plus w/SBA (Prepaid) HealthChoice Dental Plan
 Assurant Heritage Secure (Prepaid) MetLife Classic
 CIGNA Dental Care Plan (Prepaid) MetLife Value MAC Member Primary Dentist (Prepaid only)
 Delta Dental PPO MetLife Value PDP New Patient Current Patient
 Delta Dental PPO – Choice

Vision Plan No Change Add or Change Vision Plan Drop Vision Plan

To ADD or CHANGE your vision plan, select from the options below:

- Primary Vision Care Services Vision Service Plan
 Superior Vision Vision Care Direct

Member Life Plan No Change Drop all Life Insurance
 Decrease Life Insurance to \$ _____ (in \$5,000 units)

DEPENDENT CHANGES

SPOUSE

Name _____ SSN _____
 Pre-Medicare OR Medicare

ADD DROP

- N/A Health Date of Birth _____ Male Female
N/A Dental Primary Physician _____ New Patient Current Patient
 Vision Primary Dentist _____ New Patient Current Patient
N/A Dependent Life Decrease Dependent Life amount to \$ _____ (in \$500 units)

CHILD

Name _____ SSN _____
 Pre-Medicare OR Medicare

ADD DROP

- N/A Health Date of Birth _____ Male Female
N/A Dental Primary Physician _____ New Patient Current Patient
 Vision Primary Dentist _____ New Patient Current Patient
N/A Dependent Life Decrease Dependent Life amount to \$ _____ (in \$500 units)

CERTIFICATION SIGNATURES

You must sign this form. Additionally, if you and/or your Medicare eligible dependents are enrolling in or changing to a different Medicare Supplement or MA-PD plan, you/they must obtain and complete a separate enrollment application AND complete and return this Option Period form to OMES EGID.

Member Signature _____ Date _____

Your spouse must sign if they are being excluded from health and/or dental coverage.

Spouse Exclusion Certification (Required only if dropping spouse while continuing to cover children):
I certify that I am aware I am being excluded from health and/or dental coverage as indicated on this form.

Spouse Signature _____ Date _____

If making changes, complete and return no later than Dec. 7, 2016, to:
OMES EGID, P.O. Box 58010, OKC, OK 73157-8010